Quality Assurance

The meeting and preparation time for quarterly Quality Assurance meetings, including committee members of a physician, director of nursing, administrator or designee and three other staff was estimated by the industry. This was offset by the elimination of separate pharmacy reviews and infection control meetings, as well as the existing utilization review assessment and U/R committee meetings. Three added staff involved in meetings are assumed to be the physical therapist, social services director, and a representative from medical records. The net added expense estimated by the industry was $600,264.

Recertification of Nurse Aides

The number of aides who must be recertified by 1/92 is 17,381. The cost of recertification is $25.00 per aide. The total recertification cost is $434,525.

Psychotropic Drug Reviews

The code requires that all residents receiving psychotropic medications be reviewed with the intent of minimizing the usage of such drugs. These reviews are assumed to involve the physician and take about .5 hours per resident. It is estimated that 20% of residents will need such review at a physician cost of $150 per hour.

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105,000 x 20% x .5 x $150 = $1,575,000

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Surety Bonds

The industry has estimated that $189,000 of added cost will be incurred for this requirement and was found acceptable.

SUMMARY OF INCREMENTAL CODE COSTS TO BE REIMBURSED

Total incremental federal code cost to be recognized in facility 1991 rates is $17,041,640.

Comprehensive Resident Assessment	$ 2,797,200
Quarterly Resident Assessment	2,772,000
Comprehensive Care Plan	6,917,631
Quarterly Care Plan Review	1,386,000
Training of MDS+[5] Assessment	370,020
Quality Assurance	600,264
Nurse Aide	434,525
Psychotropic Drug Review	1,575,000
Surety Bonds	189,000
Total Incremental Cost	$17,041,640

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[5]MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)

Costs are to be reflected in facility rates beginning July 1 1991, so that the nine months of incremental cost from April 1, 1991 to December 1991 will be reflected in the six month rate period July to December 1991. Total incremental costs were converted to a per diem add-on to be included in a facility's rate by dividing total incremental costs by available beds, and adjusting to days by dividing by 365. The calculation is as follows:

$17,041,640 / 105,000 / 365 = .45 add-on

This statewide add-on will be adjusted for each facility to reflect regional differences in RN salary levels for calendar year 1987. Such regional adjustments are currently used in the determination of the direct and indirect components of facility rates. For 1992 and forward, the incremental cost add-on will be increased by the appropriate trend factor.[6]

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[6] Trend factors are computed in accordance with Section 86-2.12 of this Plan.

Description of Methodologies for the Physical, Mental, and Psychosocial Well Being Requirement

The State of New York reimbursement rates match payment with intensity of care, thus providing facilities with adequate reimbursement for patients requiring more intensive supportive, medical or rehabilitative care. The RUG II patient classification system classifies each patient into one of sixteen patient categories which are each different in terms of clinical characteristics and are statistically different in terms of costs of care.

The system uses a hierarchy of patient types and secondary subgroup format based on Activities of Daily Living (ADL) function levels. The five hierarchical groups, from the highest to lowest resource consumption, are as follows:

1. Special Care
2. Rehabilitation
3. Clinically Complex
4. Severe Behavioral Problems
5. Reduced Physical Functions

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Each of the above clinical groups is further divided by the ADL index score into subgroups. The ADL index is comprised of three ADL variables, eating, toileting, and transfer, which were determined to be the key predictors of resource consumption within each clinical group. For each of the sixteen patient classification categories, a relative resource "weight" representing the resource consumption of patients in that category relative to the average patient, is used to adjust the direct component of the payment rate.

The RUGS system thus allows a more precise and equitable means of directing available fiscal resources to nursing homes that care for residents with the heaviest care needs. By recognizing the resources required to provide more intensive rehabilitative and support services, the reimbursement methodology encourages nursing homes to establish restorative care programs. This can result in more active intervention for eligible patients, and earlier improvement and discharge.

October 1, 1992

For rates effective January 1, 1992 and thereafter, the per diem add-on described herein will be increased by a trend factor as defined in Section 86-2.12 of this Plan.

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86-2.10 (#97-3)
Attachment 4.19-D
Part I

Description of the specific methodology for determining the adjustment - Bloodborne Pathogens

Hepatitis B Vaccination:

Beginning January 1, 1993 and thereafter, provider rates contain a facility-specific adjustment to reimburse the cost of the Hepatitis B vaccine administered to employees. Provider-specific adjustments are based upon each facility's actual costs recognized up to a maximum cost for the vaccine. The facility specific adjustment will be determined using costs reported by the providers two years prior to the start of the rate year. The maximum cost for the vaccine that is recognized when setting the facility specific adjustment is $128.50 for a three vial series per employee.

Gloves:

For rates effective on April 1, 1994 for the 1994 calendar year and each calendar year thereafter, an $.18 per diem adjustment will be included in provider's rates for the incremental cost of gloves.

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Reserved.

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Attachment 4.19-D
Part I

(v) Extended care of residents with traumatic brain injury.

(1) (i) Except as provided in subparagraph (ii) of this paragraph, effective April 1, 1993, a per diem amount of $25, adjusted by the RDIPAF determined pursuant to paragraph (5) of subdivision (c) of this section, and increased in rate years thereafter, by the projection factors determined pursuant to section 86-2.12 shall be added to a facility's payment rate determined pursuant to this Subpart for each resident with traumatic brain injury identified as requiring extended care and receiving services pursuant to section of this Title.

(ii) Effective with rates revised based upon patient review instrument (PRI) assessment data for an assessment period set forth in Section 86-2.11(b) of this Subpart beginning on or after November 1, 1994, a TBI patient per diem amount shall be added to a facility's average Medicaid payment rate determined pursuant to this Subpart only for Medicaid residents with traumatic brain injury identified as requiring extended care which shall mean a person who is at least three months post-injury and who has been diagnosed as having a cognitive and/or physical condition that has resulted from traumatically acquired, non-degenerative, structural brain damage, or anoxia, and who in addition has participated in an intensive inpatient rehabilitation program for persons with TBI in a hospital or nursing home and has been assessed by a neurologist or physiatrist who determined that the individual would no longer benefit from an intensive rehabilitation program. The TBI patient per diem amount shall be determined as follows: The total number of Medicaid traumatic brain injury (TBI) extended care residents shall be multiplied by $25 per patient day times 365 days to determine the annual TBI amount. The annual TBI amount shall then be adjusted by the facility RDIPAF, determined pursuant to subdivision (c)(5) of this section, to establish the allowable TBI dollars. The allowable TBI dollars shall be divided by the facility total annual Medicaid days to determine the facility TBI patient per diem amount. The TBI patient per diem amount shall be increased annually by the projection factor determined pursuant to section 86-2.12 of this Subpart. For purposes of this subdivision, a Medicaid resident is defined as a resident whose primary payor description is coded as Medicaid on the PRI assessment data.

(2) Residents reimbursed pursuant to this subdivision shall not be reimbursed pursuant to subdivision (n) and (o) of this section.

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New York
47(x)(2)

Attachment 4.19D
Part I

Rates of payment for non-state operated public residential health care facilities shall be increased in an aggregate amount of $100 million for payments for services provided during the period July 1, 1995 though March 31, 1996. To be eligible, the facility must be operating at the time the pool is distributed. Payment to each eligible facility shall be in proportion to the facility's 1994 Medicaid days relative to the sum of 1994 Medicaid days for all eligible facilities.

TN 95-24-A Approval Date MAR 27 1997
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OPTIONAL

New York
47(x)(2)(a)

Attachment 4.19-D
Part I

For the period August 1, 1996 through March 31, 1997, proportionate share payments in the aggregate amount of $257 million shall be made under the medical assistance program to non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. Payments shall be made as a lump sum payment to each eligible residential health care facility.

The amount allocated to each eligible public residential health care facility shall be calculated as the result of $257 million multiplied by the ratio of 1994 facility Medicaid patient days divided by the total of all Medicaid patient days for all eligible public residential health care facilities. The payments are made contingent upon receipt of all approvals required by federal law or regulation.

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